Clermont County Life Enrollment Form

(All Benefit Eligible Employees Must Complete This Form)

Personal Information

Name	Full Time Hire Date	Annual Salary
Address: Street Address, City, State, Zip		

Clock #	Date of Birth	Social Security #	Employee Work Phone #
Department Number		Department Name	

Life Insurance

Effective 1/1/2008, Clermont County increased life insurance coverage for full-time employees to $25,000 in Basic Life & $25,000 in AD&D coverage. Coverage ends when employment terminates, however, you can apply to 'port' or 'convert' the coverage to continue it after the end of your employment by completing the appropriate vendor forms available on the county web site (www.co.clermont.oh.us) under Human Resources.

ALL EMPLOYEES MUST COMPLETE THIS SECTION:

Beneficiary Designation (Basic and Voluntary Life and AD&D)

Name	Relationship	Date of Birth	Address	Share %

Contingent Beneficiary Designation (in the event my primary beneficiary(ies) predecease me)

Name	Relationship	Date of Birth	Address	Share %

Voluntary Life Insurance

This is additional, optional coverage and is 100% employee paid. The cost is age-rated (see the rate chart). You must have employee coverage in order to cover your spouse and/or child(ren). Spousal coverage cannot exceed employee's coverage; Child life cannot be more than 50% of the employee's coverage. Coverage ends when employment terminates, however, you can apply to 'port' or 'convert' the policy to continue beyond termination by completing the appropriate vendor available on the county web site (www.co.clermont.oh.us) under Human Resources. *See Plan Summary for coverage limitations.

Voluntary Life Costs: The rate chart is located on the County web site: www.co.clermont.oh.us, under Human Resources.

Type		Date of Birth	Life Amount	Per Pay Contribution
	Employee		$	$
	Spouse Name:		$	$
	Children Name(s):		$	$
			Total Payroll Deduction (24 pays annually):	**$**

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the information about DELAYED EFFECTIVE DATES AND EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____